DCH/LDN-501 (03/04)

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

DENTIST LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS:

Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Please provide details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may result in a delay in the processing of your application.

DENTIST LICENSURE BY EXAMINATION

1. Submit a completed application and proper fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application and fee are no longer valid.

2. The licensing agency of all states in which you are or have ever been licensed must complete and submit a Verification of Licensure form.

3. Submit a FINAL, OFFICIAL transcript of dental education. This transcript must be sent to the Michigan Board office by the school and must show the date of graduation, the degree or certification earned, and have the seal of the school. **It is the applicant's responsibility to arrange to have the transcript mailed directly to the Board office by the school.** (Copies, student transcripts or incomplete transcripts are not acceptable.)

4. Contact the National Board of Dental Examiners, 211 E. Chicago Avenue, Ste 1846, Chicago, Illinois 60611, telephone (312) 440-2678, or website: www.ada.org/prof/ed/testing/natboard, to request that an OFFICIAL REPORT of your National Board scores be sent directly to the Board office. (Copies of examination scores are not acceptable.)

5. If you have taken and passed the Northeast Regional Board Examination (NERB) since January 1970 or the 1995 Combined Regional Examination (CORE), the Board office has the examination records. If you have not taken either examination, contact the office of the Northeast Regional Board of Examiners, 8484 Georgia Avenue, Suite 900, Silver Spring, MD 20910, telephone (301) 563-3300, or website: www.nerb.org, for an application and information on the site and date of the next examination.

A license cannot be issued until all of the above requirements have been met.

GRADUATES OF NON-ACCREDITED AND FOREIGN SCHOOLS

Michigan Board of Dentistry Administrative Rules require graduates of non-accredited or foreign dentistry schools complete a two-year dental program in an ADA accredited school. Upon successful completion of the two-year program, we must receive a final, official transcript directly from the non-accredited or foreign school and the ADA accredited program. If the transcripts are not in English, a translated copy must also be provided. The applicant will then be made eligible for the NERB examination.

LIMITED LICENSE

The Public Health Code of Michigan (1978 PA 368, as amended) provides that the Michigan Board of Dentistry may grant the following types of limited licenses:

1. Educational Limited License - to a person who is enrolled in postgraduate education.

2. Non-clinical Academic Limited License - to a person who functions ONLY in a non-clinical academic, research or administrative setting and who does not hold themselves out to the public as being actively engaged in the practice of dentistry, or otherwise solicit patients.

3. Clinical Academic Limited License - to a person practicing only in a clinical academic setting and who does not hold themselves out to the public as being actively engaged in the practice of dentistry, or otherwise solicit patients.

The Board of Dentistry Administrative Rules and procedures require the submission of the following for each type of limited license:

1. Proof of graduation (official transcript) from an ADA approved dental education program OR a certified copy of the diploma and transcript from an unapproved school of dentistry. The latter shall be translated into English, if necessary.
2. Name, address and division/department of institution in which the applicant is being employed/enrolled;
3. Name, degree and title of applicant's supervising dentist;
4. Description of duties, responsibilities or courses of the applicant; and
5. Beginning date of employment or the beginning and anticipated ending date of the education program.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

DCH/LDN-010 (03/04)

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR DENTIST LICENSE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only
License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- ❒ Dentist License Fee: $120.00 71-2901-01
- ❒ Dentist Clinical Academic License Fee: $50.00 71-2901-03
- ❒ Dentist Non-Clinical Academic License Fee: $50.00 71-2901-03
- ❒ Dentist Educational Limited License Fee: $50.00 71-2901-05

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		

Have you ever held a health professional license in Michigan?

❒ No ❒ If yes, list Michigan permanent I.D./license number and expiration date: _____

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	❒ Yes ❒ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	❒ Yes ❒ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	❒ Yes ❒ No
4. Have you been treated for substance abuse in the past 2 years?	❒ Yes ❒ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	❒ Yes ❒ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ❒ Yes ❒ No

7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ❒ Yes ❒ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ❒ Yes ❒ No

9. Do you hold or have you ever held a full dental license (other than an educational, temporary or limited license) in any state? List each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ❒ Yes ❒ No

State	License/Registration Number	Date of Issue	How Obtained (Endorsement or examination)

10. Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree

Name

11. Have you passed all parts of the National Board Exams? ☐ Yes ☐ No

If No, please list the date you are scheduled to take the exam: _____

Have you ever taken the Northeast Regional Board Examination (NERB) or the Combined Regional Exam (CORE)?

☐ Yes ☐ No Date Scheduled: _____

If Yes, complete the following:

Examination Date: _____ ☐ Pass ☐ Fail

Reexamination Date: _____ ☐ Pass ☐ Fail

Reexamination Date: _____ ☐ Pass ☐ Fail

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

DCH/LPH-090 (07/04)

Board Use Only
Date of Licensure
License Number

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, prescribe, or dispense controlled substances. If you are an M.D., D.O., D.P.M., D.D.S., O.D. or D.V.M. who prescribes at more than one location, a controlled substance license is required for each location. Please submit a separate application for each location.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: **Initial (first time) professional license or relicensure of your professional license - $85.00. If you already hold a professional license and your professional license expires in:**

0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

THIS LICENSE VALID - ONLY AT THE FOLLOWING LOCATION

Street	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐		
☐ 51 - 01 D.O. 71-5315	☐		
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

☐ **Yes** ☐ **No**

If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**

☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

www.michigan.gov/healthlicense

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.